

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

461888

STATE FILE NUMBER

FILED DEC 20 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11990

S. 300  
ov. 1-57

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis.</b>  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY<br>OR<br>TOWN <b>St. Louis.</b>                                    |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | d. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Enroute Christian Hospital</b> |  | Length of stay in lb  |  | e. STREET<br>ADDRESS <b>5383 Wabada</b>                                    |  |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  | 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Mike</b> Middle Last <b>Pappas</b>                               |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>11,</b> Year <b>1957</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 6, 1897</b>                                    |  |
| 9. AGE (In years last birthday) <b>60</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>       |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Business</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Argos, Greece.</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13a. FATHER'S NAME<br><b>Unknown</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Faye Pappas</b>                          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, name unknown) (If yes, give year or dates of service)<br><b>No. Nil.</b>   |  | 16. SOCIAL SECURITY NO.<br><b>488-03-8669</b>   |  | 17. INFORMANT<br>Address<br><b>Faye Pappas, 5383 Wabada, Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart disease</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b><br>DUE TO (c) <b>Atherosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 months</b>                       |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>443x</b>   |  |  |  |
| 20c. TIME OF INJURY<br>Hour<br>a.m.<br>p.m.  |  |   |  |   |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                            |  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY STATE   |  |
| 21. I attended the deceased from <b>March 1954</b> to <b>November 1957</b><br>Death occurred at <b>3:22 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |  | 22a. SIGNATURE (Degree or title)<br><b>J. H. Hoppe M.D.</b>   |  |  |  |
| 22b. ADDRESS<br><b>9739 N. Grand</b>   |  |   |  | 22c. DATE SIGNED<br><b>DEC 13 '57</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>12-14-57</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Matthews Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>     |  |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe 4700 Washington, Blvd.</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 13 '57</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>J. Earl Smith, M.D.</b><br><b>m. j. B.</b> |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
- All diseases in Part I must be causally related.

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Melvin L. Kessinger*

Licensed Embalmer No. *405-2*

P. O. Address *Washington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.